

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155477		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/29/2011	
NAME OF PROVIDER OR SUPPLIER LANE HOUSE				STREET ADDRESS, CITY, STATE, ZIP CODE 1000 LANE AVE CRAWFORDSVILLE, IN 47933			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00100745.</p> <p>Complaint IN00100745: Unsubstantiated, lack of evidence</p> <p>Survey dates: December 28 and 29, 2011</p> <p>Facility number: 000462 Provider number: 155477 AIM number: 100275380</p> <p>Survey team: Vanda Phelps, RN</p> <p>Census bed type: SNF/NF 47 Total 47</p> <p>Census payor source: Medicare 8 Medicaid 33 Other 6 Total 47</p> <p>Sample: 4</p> <p>The Lane House was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the investigation of complaint number IN00100745.</p> <p>Quality review completed 12/30/11 Cathy Emswiller RN</p>			F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.